

LOG OF INCURRED MEDICAL EXPENSES

State Form 11131(R2 / 2-96) / FI 0008

For the month of:

Date completed

INSTRUCTIONS TO CASEWORKER: *This form must be completed accurately and legibly. Prescription medication must be clearly identified.*

Recipient's name		Names of others whose incurred medical expenses are allowed:
Case number (<i>Case / Cat. / Seq.</i>)	RID	

[illegible]

Signature of caseworker	Total incurred expenses	\$	Total incurred by recipient on effective date	\$
	Subtract third party payments	—	Amount Medicaid can pay	—
Signature of recipient or person acting in his behalf	Total allowable expenses	=	Deductible	=
	Spend-down amount	—	Effective date	
	Amount Medicaid can pay	=		

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NAME	DATE OF SERVICE	NAME OF PROVIDER	TYPE OF SERVICE	AMOUNT	VERIFICATION
				THIRD PARTY PAYMENT	
				\$	